

**Appendix A**

**NORTHWEST ANTICOAGULATION CLINIC**

**Physician Referral/Collaborative Care Form**

Phone: (206)668-1282/ FAX: (206) 368-6045

**Patient Name:** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Sex** \_\_\_\_\_  
**Patient's Phone:** \_\_\_\_\_ **Cell:** \_\_\_\_\_  
**Other contact number/person:** \_\_\_\_\_  
**Attach face sheet or provide Address:** \_\_\_\_\_  
\_\_\_\_\_

**Indication for Anticoagulation:** \_\_\_\_\_  
**ICD9 or ICD10 code(s)** \_\_\_\_\_  
**Target INR Range:** \_\_\_\_\_  
**Suggested date of first appointment?** \_\_\_\_\_  
(Clinic closed weekends and holidays)

**Anticipated Duration of Anticoagulation:** \_\_\_\_\_

**Current Warfarin Strength and dosage regimen:** \_\_\_\_\_  
**Date of last INR** \_\_\_\_\_ **and INR value** \_\_\_\_\_

**Complicating Factors/Other Diagnosis: Attach H&P, medication list, problem list and warfarin flow sheet if available**

I, \_\_\_\_\_, the referring physician  
(Please print)  
will be the collaborative physician of record, granting prescriptive authority to the clinical staff according to the protocol approved by the Washington State Board of Pharmacy.

**Phone:** \_\_\_\_\_

**FAX Number:** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_